State Plan 2001: Blueprint for Change

Table of Contents

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Chapter 1. Strategic Plan

Introduction and Overview

North Carolina's mental health, developmental disabilities and substance abuse services system is at a crossroads. The state's ability to respond to rapidly changing national standards has been severely compromised by reductions in funding, changes in leadership, a lack of consensus regarding how to improve the system, and severe budget problems. Consumers, families, advocates, providers, legislators and administrators recognize that sweeping changes are needed to move the system forward into the 21st century.

The North Carolina General Assembly has taken an increasingly active leadership role in the public system for mental health, developmental disabilities and substance abuse services. During the 2000 Legislative Session, the bipartisan Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services was established to oversee system reform. The LOC, chaired by Senator Steven Metcalf and Representative Verla Insko, created the mental health reform bill. Governor Michael F. Easley signed the bill on October 15, 2001. The mental health reform bill (House Bill 381: An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level) provides much of the basis for this state plan, particularly as it relates to coordination of state and local collaboration. The full text of the reform legislation is incorporated by reference as a separate document.

The *State Plan 2001: Blueprint for Change* is DHHS Secretary Carmen Hooker Buell's plan to transform the present system. It is a living document for a five-year period of time that will be refined as the state plan is implemented. The State Plan will ensure on-going consumer and family involvement and oversight. The State Plan prioritizes services for people with the most disabilities, employs evidence-based best practices, and promotes efficiency. It realigns service priorities and reallocates system resources. It accepts limited funding as a fact and recognizes that the current economic downturn is expected to continue. North Carolina's financial shortfall makes it essential that the service system channel funding to direct services. The State Plan sets clear limits on indirect service costs and opts for the most cost efficient service delivery available.

Assumptions

The Secretary's charge included the following assumptions:

Nothing Sacrosanct – Any program, service, value, tradition or custom must work or it goes.

Political Concerns Not Primary – Turf protection will not be allowed.

Vastly Increased Funding Unlikely – The State's current financial struggles will continue.

System Must Be Simplified – Statutes, rules and the new system design elements must be clear and concise.

Mission, Principles, Vision

The plan rests on the mission statement of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (Division) and emphasizes quality assurance and continuous quality improvement principles.

Mission

North Carolina will provide people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary, prevention, intervention, treatment, services and supports they need to live successfully in communities of their choice.

Guiding Principles

Treatment, services and supports to consumers and their families shall be appropriate to needs, accessible and timely, consumer-driven, outcome oriented, culturally and age appropriate, built on consumer's strengths, cost effective, and reflect best practices.

Research, education and prevention programs lower the prevalence of mental illness, developmental disabilities, and substance abuse; reduce the impact or stigma; and lead to earlier intervention and improved treatment.

Services should be provided in the most integrated community setting suitable to the needs and preferences of the individual and planned in partnership with the consumer.

Individuals should receive the services needed, given consideration of any legal restrictions, varying levels of disability, and fair and equitable distribution of system resources.

System professionals will work with consumers and their families to help them get the most from services.

Services will meet measurable standards of safety and quality and demonstrate a dedication to excellence through adoption of a program for continuous performance improvement.

All components of the system will be clinically effective and operated efficiently.

Vision

Public and social policy toward people with disabilities will be respectful, fair, and recognize the obligation to assist all who need help.

The state's service system for persons with mental illness, developmental disabilities and substance abuse problems will have adequate, stable funding.

System elements will be seamless: consumers, families, policymakers, advocates, and qualified providers will unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.

All human services agencies that serve people with mental health, developmental disabilities and/or substance abuse problems will work together to enable consumers to live successfully in their communities.

Consumers will have:

- Meaningful input into the design and planning of the service system.
- Information about services, how to access them, and how to voice complaints.
- Opportunities for employment in the system.
- Easy, immediate access to appropriate services.
- Educational, employment or vocational experiences that encourage individual growth, personal responsibility and enjoyment of life.
- Safe and humane living conditions in communities of their choice.
- Reduced involvement with the justice system.
- Services that prevent and resolve crises.
- Opportunities to participate in community life, to pursue relationships with others and to make choices that enhance their productivity, well being and quality of life.
- Satisfaction with the quality and quantity of services.
- Access to an orderly, fair and timely system of arbitration and resolution.

Providers will have:

- Opportunity to participate in the development of a state system that clearly identifies target groups, core functions, and essential service components.
- Access to an orderly, fair, and timely system of arbitration and resolution.
- Documentation and reimbursement systems that are clear, that accurately estimate costs associated with services and outcomes provided, and that contain only those elements necessary to substantiate specific outcomes required.
- Training in services that are proven.

Challenges of Change

The State Plan will be phased in. Many services currently provided through institutions will be transitioned to communities. The state's business plan is contained in this document—a general overview, the state plan timeline, and the state business implementation document. Local business plans, adopted by the counties, will ensure that this transition is properly planned and goes smoothly. Regional providers will be adjusted to account for a changing population and service mix. Area/county programs will move quickly to an area-wide planning and managing approach. Funding will be studied and realigned over time.

Bringing substantive change is difficult for public systems that have existed for a long time and where day-to-day practices have become traditions that are respected and valued as much for their antiquity as they are for their effectiveness. Change is essential to keep up with new research about what works.

This State Plan is:

- Proactive.
- Requires change in the most basic structures and processes of the system.
- Clearly defines the purpose, consumers, and services of the system.
- Requires every individual, qualified provider, and agency to keep faith with the new mission and vision.
- Develops solutions from the perspective of what is needed and what methods are proven to work.
- Requires that everyone work together to build a new and better system.
- Requires county government leaders to engage all of their citizens in discussion and decision-making about governance and local business plans.
- Requires the number and governance of area agencies to change as the mental health reform legislation is implemented.

Chapter 2. A Description of the Current System

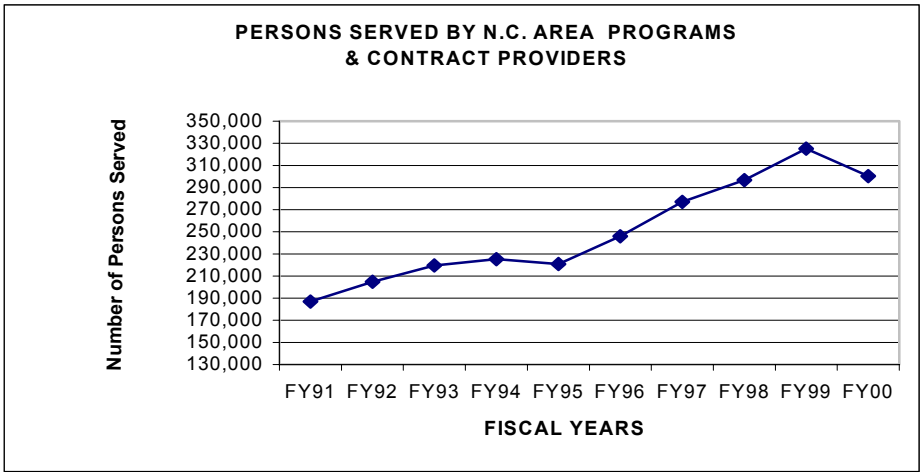
The North Carolina mental health, developmental disabilities, and substance abuse service delivery system includes state employees, local government employees in area authorities, and an extensive network of qualified providers operating under contracts with the state Medicaid agency or with the area programs. The total system budget is nearly $1.7 billion dollars, almost one-tenth of the state's overall expenditure.

The Division is responsible for oversight of North Carolina's public service system provided through state facilities, 38 area programs, and a large number of contracted qualified providers. The Division consists of central office staff and state facilities. The central office organization is composed of the Director's Office, Adult Community Mental Health Services, Child and Family Services, Substance Abuse Services, and Developmental Disabilities Services. It also includes administrative sections like budget and information technology to handle the division's support services. The Division operates state hospitals, mental retardation centers and residential facilities for children and youth.

Other divisions of the Department of Health and Human Services, such as the Division of Medical Assistance, the Division of Social Services, and the Division of Facility Services play key roles in the administration and funding of the system. These divisions should work together, but they often work at cross-purposes with each other. There also is a need for improved collaboration with other departments within state and county government.

Area Programs and Qualified Providers

Area programs are at the center of community-based service delivery of services and supports in North Carolina. Area programs provide services directly or contract to provide services. The state also recently began to contract directly with providers. The 38 area programs provide services to specified geographical (catchment) areas covering all of North Carolina's 100 counties. Funding for these programs in FY 99 was $751,541,709.



In FY 2000, programs served a total of 300,245 individuals; a 61 percent increase over the past ten years.
An area authority---generally a local political subdivision of the state---currently governs each area program, except Mecklenburg and Wake counties. County commissioners appoint area authorities' board members.

Area programs' budgets, staffing patterns, operations and populations vary considerably. Area programs treat relatively few persons with severe and persistent mental illness. Children and youth, and developmental disabilities services also rank far below what would be expected statistically. There is strong financial pressure to use state psychiatric hospital beds for people with severe needs to shift the cost of care from the area program to the state. Mental retardation center and alcohol and drug abuse treatment center (ADATC) admissions are also paid by the state.

Caseloads, productivity, and program components differ from area program to area program. Budget cuts have reduced area program options. The state limit on administrative costs has also caused some programs to channel amounts of their funding away from direct care services. It has been estimated that up to $100 million dollars each year is spent on area program administrative and general support costs. This does not include administrative or general support paid to contract or independent or enrolled providers.

Area programs and their contract providers served a total of 300,245 people in FY 2000. Increasingly, area programs have used contract providers in addition to direct Medicaid enrolled providers. Private providers carry out almost 60 percent of the services. Area programs provide or contract for a range of services. Not all services are available statewide. In areas with a fairly broad range of services, the capacity is far less than the need.

State Psychiatric Hospitals and Special Care Center

The Division operates four regional psychiatric hospitals and one specialty long-term care facility, providing inpatient services to people with disabilities within the state. They are:

- Broughton Hospital, Morganton, 521 beds
- Cherry Hospital, Goldsboro, 588 beds
- Dorothea Dix Hospital, Raleigh, 503 beds
- John Umstead Hospital, Butner, 513 beds
- NC Special Care Center, Wilson, 248 beds

These institutions are accredited by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) and are certified by the Centers for Medicare and Medicaid (CMS) — the federal agency that administers the Medicare and Medicaid programs.

These facilities employ over 5,700 staff that include 135 psychiatrists and other physicians, 58 psychologists, 824 registered nurses, 141 social workers, and over 2,000 health care technicians. Support staff include 431 dietary, 358 maintenance, 25 police, and 415 clerical employees. Each year the facilities perform 20,000 dental procedures, 52,000 radiology studies, 1.6 million laboratory tests, and serve over three million meals. Annual expenditures total $300 million.

Mental Retardation Centers

The Division operates five regional mental retardation centers. They are:

- Black Mountain Center, Black Mountain, 73 residents
- Western Carolina Center, Morganton, 346 residents
- O'Berry Center, Goldsboro, 336 residents
- Murdoch Center, Butner, 601 residents
- Caswell Center, Kinston, 548 residents

The centers are certified as Intermediate Care Facility/Mental Retardation (ICF/MR) level of care by CMS.

The centers primarily serve adults with severe and profound mental retardation, many of whom have significant physical disabilities and/or medical fragility. Services provided by the centers include communication; recreational, occupational, and physical therapies; psychology; education; pharmacy; dietary; medical and advocacy.

These centers employ over 5,600 staff that includes 25 physicians/psychiatrists, 63 psychologists, 390 RNs/LPNs, 30 social/clinical workers, 2,200 health care technicians, 150 therapists, 150 teachers, 10 pharmacists, 100 youth program assistants, and 420 developmental disability trainers. Support staff include 280 dietary, 220 maintenance, 250 clerical, 270 housekeepers, and 20 information technology employees. Annual expenditures in FY 00-01 were approximately $238,374,000.

Residential Treatment Facilities for Children

Wright School
Wright School serves 24 children ages 6-12, focusing on the treatment needs of school age children from around the state. Wright School uses a Re-Education model that teaches children appropriate ways of interacting in their environment. Because the child's home environment is incorporated into treatment, children must be able to go home or to alternative community placement on weekends. Wright School provides a staff-secure setting for treatment and has staff on duty 24 hours a day to ensure appropriate supervision.

Whitaker School
Whitaker School is a residential treatment center located on the grounds of John Umstead Hospital, for 38 youth, ages 12-17. It serves adolescents statewide and also uses the Re-Education model. Children are encouraged to go home or to an alternative community placement on weekends. Whitaker School is a locked, physically secure treatment setting with staff on duty 24 hours a day to meet the needs of children served.

Eastern Adolescent Treatment Program
The Eastern Area Treatment program serves eight youngsters, eight to 12 years old. The program is located at the Special Care Center in Wilson. This program functions as a Psychiatric Residential

Treatment Facility, which is a secured, non-medical behavioral and emotional treatment center for children with mental illness or substance abuse problems.

The three youth facilities employ over 175 staff that include three psychologists, eight therapists, two nurses, one advocate, 28 teachers, three social workers, 78 youth program assistants, 18 educational development aides, and seven clerical staff. Annual expenditures in FY 00-01 were $8,413,219.

Alcohol and Drug Abuse Treatment Centers

Julian F. Keith ADATC, Black Mountain
Julian F. Keith ADATC is an 80-bed (70 rehabilitation/10 detoxification/crisis recovery) residential treatment facility for residents of Western North Carolina.

Walter B. Jones ADATC, Greenville
Walter B. Jones ADATC is a 76-bed, short-term residential treatment center serving 33 counties in the Eastern Region and five counties in the South Central Region of the state. People who are deaf or hard of hearing may be admitted from any of North Carolina's 100 counties. The Jones Center also provides treatment for pregnant and postpartum women and their infants.

Butner ADATC, Butner
Butner ADATC serves men and women from the 16 counties of the North Central Region, as well as 10 counties of the South Central Region. The center has 30 male rehabilitation beds, 15 female beds, and 15 male acute treatment beds.

The ADATCs employ over 350 staff, including 17 physicians/psychiatrists, four psychologists, 85 RNs/LPNs, eight social workers, 65 health care technicians, and 45 substance abuse counselors. Support staff include 22 dietary, 12 maintenance, 38 clerical, 21 housekeepers, and three information technology employees. Annual expenditures in FY 00-01 were approximately $12,337,000.

Summary of Needs

People Needing Services

- Almost 6 percent of North Carolina adults (322,000) have serious mental illness, and 99,000 of those have severe and persistent mental illness: 141,068 adults are being served; 35,000 are considered to have severe and persistent mental illness.
- 10 to 12 percent (between 173,069 and 207,683) of children will experience a serious emotional disturbance. The system serves 76,485 children with or at-risk of serious emotional disturbances.
- 10, 557 individuals need development disabilities services; 5,234 of them are not receiving any services/supports.

Children with Emotional Disturbances

- There was a 300 percent increase in the number of children at risk for being seriously emotionally disturbed between 1994 and 2000.
- In 1998, more than 9,100 North Carolina children waited for as long as three months for services from mental-health providers.
- It will cost $44.5 million to move all the children on the waiting list into community-based services.
- There are 73 severely challenged children on waiting lists for services who suffer from multiple disorders and require long-term specialized treatment. That community-based treatment would cost another $5.3 million.
- Lack of community-based services and overcrowded psychiatric hospitals put too many children at risk.
    - Of the 191 children and teenagers in the state's psychiatric hospitals, almost half are eligible for community services.
    - Though half the children admitted to mental health facilities are younger than 15, a lack of youth bed space means that these younger peoples are often placed with older teens, putting their safety in jeopardy.

Children with Substance Abuse Problems

Early treatment of children with alcohol and other drug problems can prevent more serious addiction problems.

- 14,000 children use substance abuse services.
- Another 7,000 children are on waiting lists for community treatment services.
- There is a 30-40 days waiting period for admission to community residential care.
- At a cost of $1,786 per child per year, the state would need to spend $12.5 million to provide adequate community-based services.

People with Substance Abuse and Other Drug Problems

An estimated 784,000 North Carolinians need additional substance abuse services; 24 percent of them have no health insurance coverage.

- 40 percent of welfare recipients need substance abuse treatment services.
- It will cost $30.2 million per year ($1,157 per client per year) to begin the most basic substance abuse treatments in communities.
- Untreated addiction results in increased health and public safety costs – last year 3,000 adults with addictive disorders were inappropriately admitted to state psychiatric hospitals, making these beds unavailable to persons with psychiatric disorders.
- The total cost to the state for housing untreated addicts in psychiatric hospitals is $13 million. That $13 million could be used in community-based treatment, if it was available.

State Facilities

The state's facilities are in desperate need of repair and renovation.

- Total repair and renovation costs for all existing state hospitals and mental health and mental retardation facilities (except for those scheduled to be closed) over the next six years is $213 million.

Local Hospitals

- Local hospitals have been forced to close 450 beds statewide, limiting options for alternative placement.
- Adequately reimbursing local hospitals for this bed space will cost $11.2 million per year.

Funding

The public system spends $1.7 billion annually; approximately 65 percent is funded through Medicaid. Funding is provided as follows:

- 22 percent to adult mental health.
- 6 percent to child mental health.
- 42 percent to developmental disabilities.
- 6 percent to substance abuse.
- 13 percent to combined mental retardation/mental illness and at-risk children.
- 11 percent to area program administration.
- less than 1 percent to state administration.

Chapter 3. Designing a New System for MH/DD/SA

The new system will be community-based. State government and county government will work collaboratively in the new system. The services will revolve around the strengths and desires of the individual, be family friendly and assure that consumers can make informed choices about care and supports. Providing services to targeted populations with the most severe disabilities is the primary focus of the new system.

Important features of the system will include use of best practices including evidence-based interventions, cultural competence, services for people who do not speak English and for people who are deaf or hard of hearing and deaf-blind; consistency and uniformity across programs; and an emphasis on quality management. Current *Clinical Guidelines* issued by the Division will be reviewed as necessary and serve as standards of care. Practice guidelines and protocols will be gathered from nationally recognized experts including, but not limited to, professional organizations, updated Division of MH/DD/SAS clinical guidelines, the *toolkits* currently being developed by the Robert Wood Johnson Foundation (RWJ) and the Substance Abuse and Mental Health Services Administration (SAMHSA), and the national movement toward self-determination including person-centered planning and supports for people with developmental disabilities.

Local service systems will be developed and managed by a Local Management Entity (LME). The county commissioners will determine the LME and approve local business plans. LMEs will collaborate with community partners to develop local business plans. LMEs will build a network of programs and providers, ensure that providers and staff are well trained, and monitor quantity and quality of services.

A system of participant-driven supports for persons with disabilities allows the individual with the disability and his/her support network the ability to make decisions regarding services and supports within budget ranges appropriate to needs. The public system must create ways to support people with disabilities to make informed decisions about how much control they want to assume over the planning and purchasing of services. In a participant-driven system the role of the professional changes from one who directs or determines the service package to one who supports the individual and family in selecting services and supports. As the transition to this new approach occurs, the system must also guard against professionals abandoning families in the name of choice, leaving them to navigate the system blindly. Families and individuals with disabilities need information, assistance and education to assist them in becoming knowledgeable about the service delivery system. Competent professional services will continue to be provided when there is a need for specialized services and supports and planning and protection will be provided for those who are unable to and have no one else to help make those decisions.

The new system must separate lifestyle decisions (i.e. where to live, where/whether to work, what to eat, what to wear, etc.) from treatment needs. These every day life decisions are often turned over to healthcare professionals who have developed healthcare service models to respond to them. People with disabilities and their families are less willing to turn to professionals for resolution of day-to-day personal decisions, but support services will continue to be available for things like housing, employment and transportation.

The main features of the redesigned system are presented in this chapter. Many elements of the new system are mandated by the mental health reform legislation, House Bill 381: An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level, passed by the General Assembly during the 2001 Legislative Session.

Core Functions

The mental health reform legislation requires that, within available resources, each LME is responsible for core functions. There are two types of core functions: service capacity such as screening, assessment and emergency triage; and indirect services such as prevention, education and consultation. Core functions may be limited and may require authorization.

- **Screening** is a brief standardized appraisal of an individual who is not currently being served within the system in order to determine the nature of the individual's problem and need for services and supports. This includes Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening and other federally mandated screening. Both financial and clinical information shall be gathered to determine the next steps. The screening process shall not be considered an evaluation or assessment. Rather, it is a brief, structured interview conducted either face-to-face or by telephone to determine whether or not the individual should be referred for further services and, if so, to where.

- **Assessment** is a follow-up step to screening. It may include an evaluation of the nature and extent of the individual's problem through a systematic appraisal of any combination of mental, psychological, physical, behavioral, functional, social, economic, and intellectual resources. Its purpose is diagnosis, determination of the person's disability and eligibility to be included in a targeted population and a determination of the urgency and intensity of need.

- **Referral** refers to offering information about available qualified providers, generic resources and community capacity to best meet the needs of the individual. This information shall be used by LME's to help determine gaps in service and network development.

- **Emergency Services** include a spectrum of functions including crisis response activities such as 24-hour crisis hotline and urgent or emergent clinic/practitioner visits. Also included is other crisis stabilization such as family/care giver respite, crisis shelters, detoxification services or emergency psychiatric hospitalization. These functions may be shared, and unless noted, not be available in every county.

- **Service Coordination** is a separate and distinct administrative function. It involves ensuring that individuals know about and are linked with the services and supports available in their communities and increasing the community's capacity to provide services and supports. This is not the same as case management. It is only person-specific when related to issues such as hospital discharge and continuity of care.

- **Consultation** is provided to other agencies, groups or organizations and to individual practitioners to promote planning and development of mh/dd/sa services. The local business plan will outline how the area/county program will provide this service to the community.

- **Education** is designed to inform and teach various groups including persons being served, families, schools, businesses, churches, industries, civic and other community groups about the nature of mh/dd/sa and services and supports in the state and community. The local business plan shall outline how education will be provided.

- **Prevention** is designed to inform and teach individuals, various groups, or the population at large about the insights and skills related to healthy living. The local business plan shall outline how prevention shall be provided.

Uniform Portal

A uniform portal system is a set of standardized processes and procedures that ensures that people throughout the state enter and leave publicly funded services in the same way. There will be many access points, but standards must be consistent. Access points shall include:

- Any public agency in the county (such as DSS, Vocational Rehabilitation, schools, Public Health).
- A statewide referral service.
- Qualified service providers in the local network.
- Local Management Entity.

A uniform access system:

- Ensures availability of information about services.
- Facilitates access to available, timely, and appropriate treatment, services.
- Provides standardized, consistently implemented, statewide procedures that comply with the Olmstead decision, and are understandable to consumers.
- Provides mechanisms for receiving and responding to feedback from people with disabilities, family members and other stakeholders.
- Provides consistent and coherent information.

Statewide System Contractor

DHHS will contract with a single agency to provide referral, a statewide crisis hotline and utilization management service. The contractor will support each LME by taking crisis hotline calls 24-hours-perday, seven-days-per-week through a single, statewide 800 number telephone system. People entering the system through any of the agencies participating in the uniform portal system shall be referred to the contractor's statewide 800 number for referral and service authorization as outlined in the local business plan. If the consumer accesses the system directly through the LME, the LME will report that data to the contractor to assure the accuracy of data collection. The contractor will screen, register and refer people seeking help to services available in their local area. The contractor will also follow up to ensure that the person actually received services. The contractor shall provide

LMEs with daily status reports and maintain a database of referrals. The contractor shall be reimbursed on a cost-plus system, and there shall be NO financial incentive for denying care.

System Access

System access will be available 24-hours-a-day, seven-days-a-week through crisis phone lines or face-to-face. People seeking services will receive a brief screening and assessment using a single standardized process. Screening will determine the seriousness of a person's needs and the proper actions to take. Everyone will have access to a reasonable and responsible level of care that meets his or her needs.

If the individual is eligible/or could be eligible for services, a referral will be made. If the ideal service is not available, interim services may be provided. If the assessment determines that the individual is not in a target population for priority services, but needs services, brief services may be provided. Referral shall be made to community-based agencies, self help groups, or faith-based initiatives, if available.

The contractor will provide utilization management (UM) – a system to ensure the most efficient and effective utilization of finite resources – statewide using standards and criteria set by the state. The state shall establish trigger points for service authorization.

Emergency services include 24/7 hotline provided by centralized UM Contractor; walk-in emergency/urgent care; crisis shelter/respite beds, and psychiatric inpatient beds. Limited service coordination and follow-up will be provided to individuals discharged from an emergency service in order to assure appropriate follow-up. Discharged individuals who are part of target populations, will be referred to the appropriate system of care. If individuals are not in a target population, referrals will be made to other services like an independently enrolled qualified provider, a community-based agency, a self-help group or a faith-based initiative.

LMEs will develop innovative, creative ways to ensure access to services for target populations. Options may include taking services to individuals in rural areas where there is little or no transportation, and/or developing comprehensive full-service clinics in county public health settings or in psychosocial rehabilitation programs, or school-based health clinics and other typically occurring work or day activities. Suitable transition plans shall be a part of each LME's local business plan.

Target Populations

Providing services to individuals with the most severe disabilities is the primary focus of the redesigned system. Selecting appropriate criteria to identify individuals with various disabilities and the greatest needs will include both diagnostic and functional elements as well as circumstances unique to each consumer. The availability and access to appropriate services that meet the needs of each person served shall also be considered. The Urgency and Intensity of Needs chart in this chapter will be applied throughout the system to establish a structured process for prioritizing services and/or managing waiting lists.

The State Plan's target populations for people with various disabilities are as follows.

Adult Mental Health Services

Recent advances in treatment for individuals with Serious Mental Illness (SMI) and Severe and Persistent Mental Illness (SPMI) make it possible for individuals with these conditions to live far more satisfying lives than ever before. The system for adults with SPMI and SMI shall adopt a rehabilitation and recovery model focusing on providing or assisting individuals to obtain the skills they need to live as normally as possible in communities of their choice.

As part of the assessment process, each adult mental health consumer is administered a Global Assessment of Functioning (GAF) test to determine how well a person is functioning. These GAF scores are one factor used to determine eligibility.

- **People with severe and persistent mental illness**: People 18 years or older who as a result of a mental illness display functioning so impaired that it interferes substantially with their capacity to remain in their communities. These people often require multiple services such as medication management, housing and transportation supports, rehabilitation and recovery activities, case management, job skills development and more. The following diagnoses are included under the category of severe and persistent mental illness: schizophrenia, bipolar disorder, major depression, schizoaffective disorder, schizophreniform disorders, psychotic disorder NOS (not otherwise specified). GAF s scores for these persons will usually be 40 or lower. Also included are individuals 18 years or older who in the past have met all criteria previously listed, as a result of effective treatment do not currently meet criteria and without ongoing treatment and supports would likely experience greater disability and again meet level of functioning criteria.

- **People with serious mental illness**: People 18 years or older who have a mental, behavioral, or emotional disorder that can be diagnosed and which substantially interferes with one or more major life activities. GAF for these people will usually be 50 or lower. Also included are individuals 18 years or older who in the past have met all criteria previously stated, as a result of effective treatment do not currently meet criteria and without ongoing treatment would likely experience greater disability and again meet the level of functioning criteria.

  Within these target populations, priority populations including racial/ethnic minorities are:
  1. **Persons with multiple diagnoses**: People 18 or older with a severe and persistent mental illness and a diagnosis of substance abuse and /or mental retardation or serious health complication like HIV/AIDS.
  2. **Homeless mentally ill:** People 18 or older with a serious long term mental illness or a serious long term mental illness and a substance abuse diagnosis who lack fixed, regular, adequate nighttime residence.
  3. **Mentally ill adults in the criminal justice system**: People 18 or older with serious mental illness who are released from the Division of Prisons, or are in local jails, or on probation.
  4. **Elderly persons**: People age 65 and over with a serious mental illness, including dementia.
  5. **Deaf mentally ill persons**: People 18 or older with a mental, behavioral, or emotional disorder that can be diagnosed and who need specialized services provided by staff who have American Sign Language skills and knowledge of deaf culture.

- **People needing care in state hospitals*:*** Shall provide psychiatric inpatient care to adults or children with severe mental illness or severe emotional disorders who cannot be appropriately treated in local communities. Admission to state psychiatric hospitals will always be a last resort, meaning when acute admission is determined to be needed and non-state operated hospitals are unable to admit the individual. The hospital shall provide care for the shortest period of time consistent with the reasonable safety of the individual and the public. Populations served are as follows.
  1. Adults and older adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression, and personality disorder requiring *acute* inpatient treatment to stabilize and return to community.
  2. Adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression, and personality disorder requiring *long-term* inpatient treatment to rehabilitate and prevent rapid relapse and readmission.
  3. Children with severe emotional disorders requiring acute inpatient treatment to stabilize and return to lower level of care.
  4. Adults and older adults with psychiatric illness and substance abuse disorders requiring acute and/or longer-term inpatient treatment to stabilize and prevent rapid relapse and re-admission.
  5. Forensic consumers, including House Bill 95 (incapable of proceeding to trial), NGRI (not guilty by reason of insanity), and others detained for legal reasons.
  6. Consumers who voluntarily agree to be part of a research program.
  7. Deaf and hard of hearing people requiring acute or long-term inpatient psychiatric services.

- **People needing care at the NC Special Care Center:** Will provide intermediate and skilled nursing care for consumers referred from state hospitals when beds are not available and intensity of psychiatric services needed are unavailable in the community.

  Specialty population to be served: People with disabilities with mid-stage Alzheimer's disease requiring nursing care.

Child Mental Health Services

All children and their families are unique, and have diverse strengths and needs that change over time within a context of developmental, environmental and social risk and support factors. The needs and circumstances of the child/youth and the related needs of the family are incorporated into each target population category.

The system shall adopt a System of Care approach that offers a holistic and cost effective opportunity to create a comprehensive, interrelated prevention and intervention service delivery system.

Child mental health consumers are administered a standardized test called the Child and Adolescent Functioning Scale (CAFAS), which determines how well a child is functioning in its daily living environment. Children are also given an Assessment Outcome Inventory (AOI) to determine how well the child handles stress factors and possesses the skills necessary to address the challenges. CAFAS and AOI results are used to determine treatment for children.

- **Children with severe emotional and behavioral problems, and their families**

Characteristics include:

1. Functional impairment that seriously interferes with or limits his/her role or functioning in family, school, or community activities:
   - Children with severe functional difficulties in home, childcare, school or community activities that lead to a CAFAS score of at least 90, or a CAFAS score 60 with at least one domain having a score of 30.
   - Presence of an extreme level of psychosocial risk as measured by the presence of 4 or more psychosocial risk factors and 10 or fewer psychosocial protective factors on the AOI Part I (Resilience Assessment).
   - Children and youth who fall into this Target Population are those from whom supports and interventions routinely provided through human service agencies are not working, those who need the highest level of support and treatment in order to regain the ability to function successfully.

AND

2. Have a serious diagnosable mental, behavioral, or emotional disturbance disorder that meets diagnostic criteria specified with DSM-IV:
   - Are identified as sexually aggressive and/or
   - Deaf and/or
   - Dually or multiply diagnosed.

AND

3. Placed out of home or at imminent risk of out of home placement as evidenced by one or more of the following:
   - Utilizing or having utilized acute mental health crisis intervention in the past year or intensive *wraparound services* in order to maintain community placement.
   - 3 or more state hospitalizations in the past year or at least 1 hospitalization of 60 continuous days.
   - DSS substantiated abuse, neglect or dependency in the past year.
   - Experienced school (or child care) failures, suspension or expulsion.
   - Conviction of a felony or 2 or more serious misdemeanors in juvenile/adult court or being currently placed in a youth advocacy program (training school), prison, juvenile detention center, *or* jail – any within the past year:

AND

4. In need of and not receiving, or not evidencing improvement from services from more than one child serving agency (e.g. MH/DD/SAS, DSS, DPI/Schools, DJJDP, Health Care, other community organizations/providers). This could include children with significant/serious chronic health conditions.

AND

5. Unable to access informal supports, as indicated by more than one of the following circumstances:
   - Support network is not accessible to the child and family.
   - Support network is overwhelmed by current needs of the child and family.
   - There are not enough supports resources to address current needs, e.g. safety.

- **Children with moderate mental health problems, and their families**

Characteristics include:

1. Functional impairment that significantly interferes with or limits his/her role or functioning in family, school, or community activities:
   - Children with moderate functional difficulties in home, childcare, school or community activities that lead to a CAFAS score of at least 60, or a CAFAS score 40 with at least one domain having a score of 20.
   - Presence of a moderate level of psychosocial risk as measured by the presence of two or more psychosocial risk factors and 6 or fewer psychosocial protective factors on the AOI Part I (Resilience Assessment).

AND

2. A diagnosable mental, behavioral, or emotional disturbance disorder that meets diagnostic criteria specified with DSM-IV.

AND

3. At significant risk of developing problems that could escalate and require out of home placement, *and/or* have a recent history (within the past 12 months) of at least one of the following:
   - Crisis intervention (an individual or family crisis), behaviors may include those that impact the safety/well-being of self and/or of others, e.g. assaults, withdrawal/depression, suicide threats/attempt.
   - Wraparound services, behaviors may include those that impact the safety/well-being of self and/or others, e.g. assaults, withdrawal/depression, suicide threats/attempt).
   - Abuse, neglect, or dependency; foster care or adoption.
   - School failure, suspension, expulsion, Special Education services.
   - Adjudication in juvenile court; conviction of at least a significant misdemeanor; diversion from court involvement; charged (but not necessarily adjudicated) with a criminal activity; on probation.

AND

4. In need of and/or receiving services from more than one child serving agency (e.g. MH/DD/SAS, DSS DPI/Schools, DJJDP, Health Care, other community organizations/providers). This could include children with significant health conditions.

AND

5. Significant difficulty accessing informal supports, as indicated by at least one of the following circumstances:
   - Support network is not accessible to the child and family.
   - Support network is overwhelmed by current needs of the child and family.
   - Available supports are not sufficient to address current needs, e.g. safety.

- **Children with mild mental health problems, and their families**

Characteristics include:

1. Have functional impairment that interferes with or limits his/her role or functioning in family, school, or community activities:
   - Children with functional difficulties in home, childcare, school or community activities that lead to a score of at least 30 on the CAFAS.

- Children who have not proven resilient enough to combat their level of psychosocial risk, as measured by the presence of 1 or more psychosocial risk factors and 4 or fewer psychosocial protective factors on the AOI Part I (Resilience Assessment).

AND

2. Children evidencing symptoms of a DSM IV diagnosable emotional disturbance.

AND

3. Children in need of and/or receiving services from at least one child serving agency (e.g. MH/DD/SAS, DSS, DPI Schools, DJJDP, Health Care, other community organizations/providers). This could include children with significant health conditions.

AND

4. Children in need of and/or receiving enhanced informal supports.

Developmental Disabilities Services

Developmental disabilities services are provided across a broad and diverse population. The target population is created by the application of a functional rather than diagnostic definition and is applicable across the lifetime of most individuals who are eligible for services.

- ***People who meet the state definition of developmental disability*** AND meet criteria for priority services and supports using the new Intensity and Urgency of Need Assessment protocol. Developmental disability means a severe, long-term disability of a person that:

  1. Is attributable to a mental or physical impairment or combination of mental and physical impairments.
  2. Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22.
  3. Is likely to continue indefinitely.
  4. Results in substantial functional limitations in three or more of the following areas of major life activity – self care, receptive and expressive language, capacity for independent living, learning, mobility, self direction and economic self-sufficiency, and
  5. Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are lifelong or extended duration and are individually planned and coordinated, or
  6. When applied to children from birth through four (4) years of age, may be evidenced as a developmental delay.

Substance Abuse Services

People with substance abuse problems face numerous and sometimes overwhelming obstacles. Due to economic status, lack of suitable housing options, and vocational/educational status, these individuals may live in unstable or unsafe environments, including households where others use alcohol or other drugs. Target populations include:

- **Injecting drug users, those with communicable disease risk and/or those on opioid maintenance therapy who are** currently injecting non-prescribed drug for non-medical reasons, assessed at Level of Eligibility 1 or 2 and meet *DSM IV* criteria for substance abuse

dependence; ***or*** infected with HIV, tuberculosis, or hepatitis B, C, or D; assessed at Level of Eligibility 1 or 2 and meet *DSM IV* criteria for substance abuse or dependence; ***or*** meet *DSM IV* criteria for dependence to an opioid drug, addicted at least one year before admission and 18 years or older.

- **Substance abusing women with children:** Adult women with *DSM IV* diagnosis of substance abuse or dependence who are currently pregnant and have Level of Eligibility 1, 2, or 3, ***or*** have dependent children and Level of Eligibility 1 or 2, ***or*** are seeking custody of child(ren) and have Level of Eligibility 1 or 2.

- **DSS involved parents who are substance abusers:** DSS involved parents who are substance abusers include those who have legal custody of a child or children under 18 and meet *DSM IV* criteria for substance abuse or dependence ***and*** are under active investigation or supervision by child protective services for suspected or substantiated child abuse or neglect ***or*** who are authorized by DSS to receive Work First assistance and/or services.

- **High management adult substance abusers:** Persons with substance abuse or dependence diagnosis and:

  1. Involuntarily committed to substance abuse treatment (legally determined to be dangerous to self or others and may have co-occurring mental illness), ***or***
  2. Have long-term substance abuse problems and Level of Eligibility 1, whose substance use pattern is recurring episodes of habitual use requiring assisted detoxification, are advanced in their disease, have no social or environmental supports, have few coping skills, may be highly resistive to treatment, may have co-occurring disorders, and may have moderate biomedical conditions.

- **Persons being served who are involved in the criminal justice system:** A criminal justice client authorized by a TASC Program Care Manager as an individual involved in the adult criminal justice system ***and*** voluntarily consents to participate ***and*** has a history of substance abuse problems, mental illness problems or charged with drug-related offense.

- **DWI Offenders:** Persons with a substance abuse or dependence diagnosis ***and*** convicted of driving while impaired, commercial DWI, driving under 21 after consuming alcohol or other drugs *and* completed DWI assessment and identified with substance abuse handicap ***and*** client pays for assessment and treatment *and* has income level 200 percent of poverty.

- **Child with Substance Abuse Disorder:** Child with substance abuse or dependence diagnosis and Level of Eligibility 1, 2 or 3.

- **Child Substance Abuse Indicated Prevention:** Designed to prevent onset of substance abuse in individuals at risk.

- **Child Substance Abuse Selective Prevention:** Prevention interventions for special subsets of populations thought to be at increased risk, such as children of adult alcoholics, dropouts, failing in school, etc.

Within target populations, prioritization will occur as follows:

- Adult and child pregnant injecting drug users.
- Adult and child pregnant substance abusers.
- Adult and child injecting drug users, and
- All others.

People with Co-occurring Disorders

Individuals with co-occurring mental illness and/or developmental disabilities, and/or substance abuse frequently have great vulnerability to stress and significant interference with their ability to live successfully in the community. While not all persons with co-occurring disorders will need the full array of services and supports available to target populations, there are groups of individuals with co-occurring disorders who should be prioritized for targeted services, including the following:

- People with serious mental illness, or severe and persistent mental illness, and minor substance abuse problems and/or mild developmental disabilities.

- People with mild mental illness and co-occurring severe substance abuse problems.

- People with a significant developmental disability and a mild mental illness or mild substance abuse problem.

- People with a serious mental illness, or severe and persistent mental illness, and/or developmental disability, and/or substance abuse problems, and a significant and chronic medical condition(s) that endangers the life or well-being of the consumer.

Intensity of Need

URGENCY OF NEED	1*	2	3*	4	5*
URGENT Examples Service/Support Need Immediate Imminent Danger of: ❑ Homelessness ❑ Interface with Justice System ❑ Institutionalization Medical/Psychiatric Emergency Death of Primary Caregiver Living in unsafe environment					
CRITICAL Examples: Will need services/supports within 12 months ❑ Aging Caregiver ❑ Facing major life transition ❑ On Waiting List X amount of time and requires service					
WAITING/PLANNING Examples: Not expected to need services/supports within the next year ❑ May need more or different services ❑ Life transition being planned for but not imminent ❑ On Waiting List					

Array of Services for Target Populations

LMEs will build community capacity to provide adequate services to target populations, including interpretation/translation services, housing options and employment opportunities. Some services and supports such as housing and transportation may be shared within various geographic areas or developed in cooperation with other agencies, qualified providers or public services. A key element for approval of each local business plan will be the creativity, innovation, breadth and inclusiveness of its proposed service array for targeted populations, including those with co-occurring disorders. The service array must be appropriate to the needs of people with disabilities in each target population, will be adjusted to the unique needs of the individual, and must meet standards derived from evidence based practices and/or nationally recognized models such as recovery or self-determination.

Housing/Residential

Housing will be designed to ensure that an individual lives with maximum independence in the least restrictive setting, including independent single or shared living quarters in communities, with or without onsite support. Options include:

- Living with family or friends with adequate support/respite services.
- Small, home-like facilities in local communities close to families and friends, with the goal of moving to a less structured living arrangement when clinically appropriate.

Residential placements shall also include any equipment and supplies needed to assist in successful, long-term housing stability. Admissions to state or private hospitals, mental retardation centers, state schools, or ADATC's are not permanent or long-term residential options.

Transportation

In areas where public transportation is available, a voucher system will be created to help clients reach services. Vouchers can also be used to pay neighbors to provide transportation. In areas where no public transportation exists, LMEs will design ways to take services to the clients or potential clients on a regular basis. The LME may need to collaborate with local public or private agencies to assist in providing services in remote areas or borrow community facilities to directly provide services on a regular basis.

Treatment, Symptom Management, Therapies

People who have psychiatric symptoms, substance abuse issues, developmental disabilities, co-occurring disorders, or other conditions amenable to medication management; physical, speech, or occupational therapy; or brief and intensive psychotherapy must have these services locally available. In urban areas, services can be offered in a broad variety of settings suitable to the needs of the individual. In rural areas, services may need to be brought to the area on a regular basis. Other interventions may include detoxification services, outpatient or inpatient substance abuse treatments with varying levels of intensity, therapeutic communities and services to those with co-occurring disorders.

Evidenced-based, best practices and emerging best practices services shall be made available to target populations. These include but are not limited to:

- The evidence-based treatment for persons with a serious mental illness or severe and persistent mental illness and co-occurring severe substance abuse problems (MISA) is the integrated treatment model. The integrated treatment approach involves the treatment of both mental illness and substance abuse problems by an individual trained in treatment of both conditions. This integrated treatment model has proven effective in greatly reducing the need for inpatient treatment of this population.
- Clinical Service Guidelines/Standards as published by the DMH/DD/SAS.
- The "toolkits" currently under development by the Robert Wood Johnson Foundaton/SAMHSA.
- Self – determination models.
- Recovery models.

Work, School, Activity, Leisure

There are a broad spectrum of services that teach living skills that make the most of the individual's ability to adapt to his/her environment, engage in meaningful work, and develop satisfying, lasting relationships. These include rehabilitation, before and after school activities, prevocational and vocational training, employment, health and wellness education, substance abuse prevention or treatment, adult day vocational programs that provide transition to employment, and others.

All services will emphasize personal empowerment, providing constant opportunities to learn, develop and exercise increasing levels of self-determination, recovery and control. Program activities will flow with the natural rhythms of daily life (i.e. work/study in the day time, recreation and play after work and on weekends). Programs will not be composed of static, repetitive activities that do not teach, develop, empower or guide the individual toward a more effective and independent lifestyle.

Over the past decade, mental health consumers and their families, supported by innovative providers and researchers, have become active in defining and advocating for new models of care. The result of these efforts has been the emergence of "recovery" as a foundation upon which best practice interventions for adults with serious mental illness are designed. Traditionally, mental health services have been designed based on the assumption that the prognosis for adults with serious and persistent mental illness is limited, at best. As a result, services have focused primarily on reducing or stabilizing symptoms. In contrast, a "recovery-oriented" model presumes that the individual can learn to effectively manage his/her symptoms, and can therefore hope for and attain a life of meaning, productivity, and satisfaction. Consistent with this newly emerging best practice model, North Carolina's services for adults with severe and persistent mental illness shall explicitly address self care, wellness, and effective coping. Further, each mental health consumer shall be provided with the opportunities and supports necessary to identify and pursue his/her aspirations for a fulfilling and personally meaningful quality of life.

Wrap-Around Services

Wrap-around services include an extensive array of services dictated by the unique needs of individuals and their families. Examples include substance abuse relapse prevention, family respite supports, family education and training, various peer supports and activities, personal support, live-in care giver, day supports, Assertive Community Treatment teams, case management and care coordination. Also included are assertive outreach, interpreter services, case consultation and any other participant-driven services/supports needed to enable individuals to live successfully in their communities.

Crisis/Emergency (Including core emergency service)

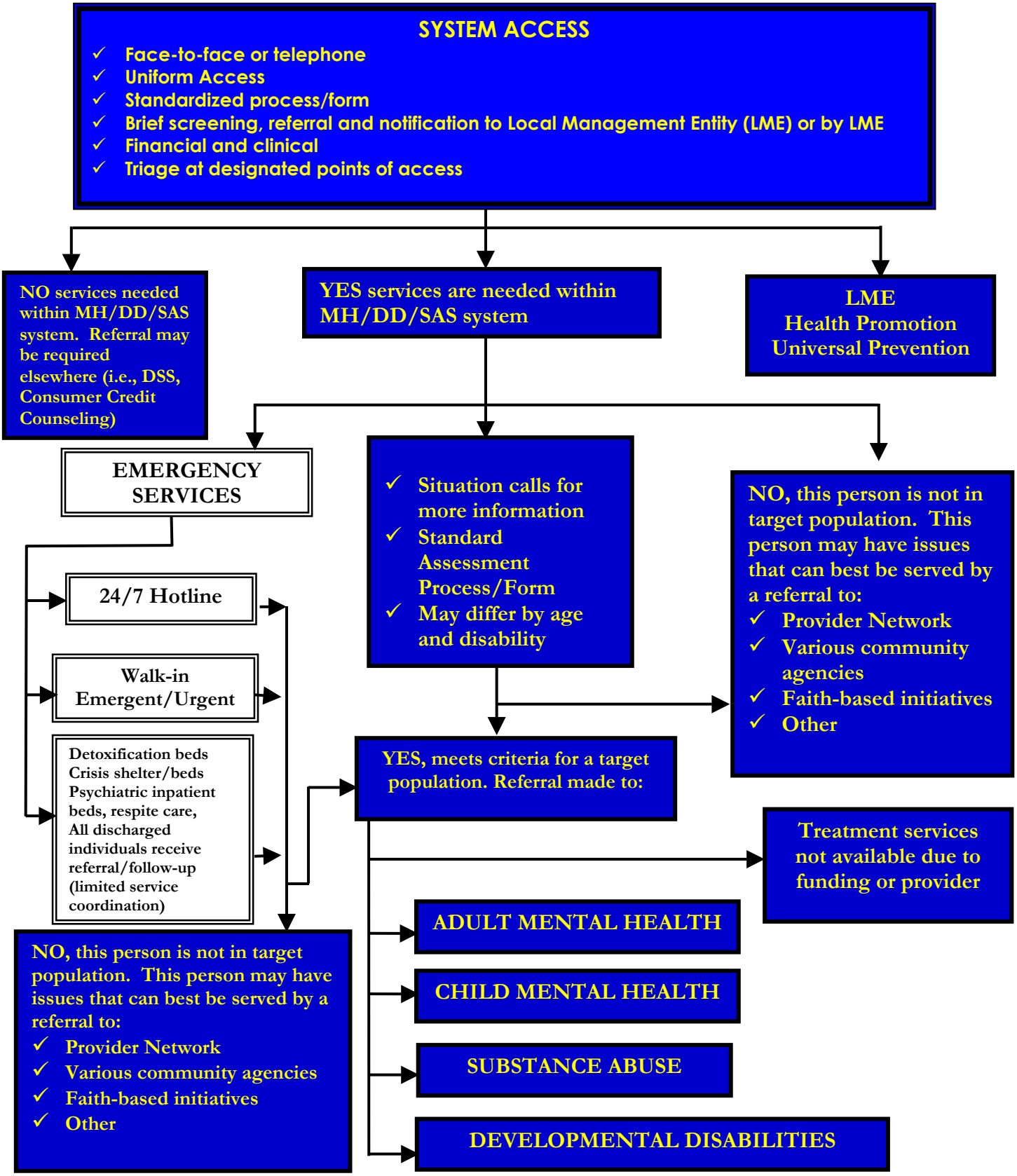
These include a range of emergency management services including short term diversion beds, crisis stabilization, after hours services, detoxification, facility-based crisis services, crisis hotline, walk-in services and inpatient hospitalization. The emphasis in emergency services must be on planning and early intervention and stabilization, avoiding the need for intensive inpatient or acute residential services.

In addition to the more traditional notion of crisis/emergency services, the range of these services will also include disaster response and recovery. Disaster response and recovery activities include crisis counseling, debriefing and defusing, and grief counseling. Within available resources such activities must be provided to anyone who is affected by a disaster.

Addressing Disparities in the MH/DD/SA System

Minority and ethnic groups are over-represented in the priority populations described in this plan. African-Americans are over-represented in our state hospitals. African-Americans are more than twice as likely to be inpatients in psychiatric facilities, and are much more reluctant to access community treatment. The Division and LMEs shall examine data to identify disparities in access to services and disparities in consumer outcomes for the following areas: race/ethnicity, gender, sexual orientation, age, disability, geographical location, income and education level. As disparities are identified, strategies shall be developed to eliminate them through the state and local business plans. An annual progress report will be issued.

UNIFORM ACCESS TO MH/DD/SAS



Local Management Entity

The Local Management Entity (LME) is the administrative body that develops, implements, oversees, monitors, and evaluates system services in a specific region or area of the state. Area programs or county governments can operate as LME's. County commissioners will decide which counties are covered by the LME and will approve local business plans.

The LME is responsible for core functions. The LME will direct the development, maintenance and oversight of a network of qualified providers sufficient to address the needs of the people in its geographic area. These functions shall be described in each local business plan and shall be approved based on established state requirements. LME adherence to these requirements will provide consistency for people with disabilities accessing the system across the state.

LMEs may not provide services except as allowed by state-adopted criteria and with the written approval of the DHHS Secretary. The primary duties and functions of the LME are:

- Develop, implement, and oversee services in a geographic area.
- Develop and implement a local business plan with its community partners.
- Continuously assess local needs for services throughout the geographic area.
- Incorporate unmet needs into the local business plan as resources become available.
- Develop and maintain a comprehensive qualified provider network for the service area.
- Assure that services are provided to individuals according to the approved local business plan and state criteria and standards.
- Develop a continuum of services for the area.
- Develop creative approaches to engaging people in target populations.
- Provide technical assistance, coaching and/or mentoring to new qualified providers.
- Evaluate statistical and other program data from the utilization management contractor to make corrections or decisions regarding clinical management and qualified provider development.
- Develop and monitor program budgets.
- Link with other public and private agencies throughout region.
- Manage multiple points of access throughout an area.
- Provide or manage functions of face-to-face screening, assessment, and referral within timeframes.
- Provide service coordination across network and assure case management for individuals in target populations.
- Assess individual and qualified provider satisfaction continually.
- Troubleshoot problems or issues of access, treatment, services and/or supports.
- Participate in state level committees, workgroups, and taskforces.
- Provide links among qualified providers of different levels of care to assure that services are provided in an integrated, seamless manner.
- Develop a disaster plan in coordination with other responsible community agencies. The plan shall address planning and preparedness activities, alert and mobilization plans and

activities, response plans and activities, recovery plans and activities. Disaster planning must be conducted according to the requirements set forth in the Division's Disaster Preparedness, Response, and Recovery Plan.

- Conduct disaster response and recovery activities in response to disasters in coordination with the other responsible community agencies and DHHS.
- Develop effective methods of communication among qualified providers and program elements.
- Assure opportunities for consumers to become a part of their communities.
- Develop employment opportunity options for consumers including consumer owned and operated businesses and competitive employment.
- Establish a Consumer and Family Advisory Committee to provide input, suggestions, recommendations, and active participation in policy and program issues.
- Provide referrals for non-targeted populations and target populations.
- Provide or manage crisis services.
- Track data required by the state.
- Assure that people receiving services and their families receive meaningful and respectful consideration of their suggestions and recommendations.
- Include people receiving services and their families in quality management and service monitoring activities.

Transition Issues

Local business plans developed by area/county programs will be the basis for transition to the new system. In order to assist the state in planning for statewide transition and to develop operational components required to implement the state plan, DHHS shall identify one or more geographic areas to pilot the plan.

Individual Transitions
Currently there are a number of individuals who are being served by the system who do not meet eligibility criteria for a target population. These clients will be transitioned out of the system over a clinically appropriate but reasonable period of time. Clients whose care, services and/or supports substantially exceed those indicated for their level of disability must be reevaluated and the level of supports realigned in order to free up resources for others who are equally or more in need of services.

Provider Network Transitions
Area planners in every region may find that the qualified provider network currently in place is not sufficient. The local business plan will address the development of a qualified provider network that delivers the range of services needed in the amounts required and the temporary measures planned to minimize the impact of gaps in the network.

LMEs' Evolving Role
All LMEs will build in transitional steps for the development of their role as leader, overseer, and manager of services in a geographic area. This planning must not disrupt or cancel existing services.

Qualified Service Provider Networks

The LME will develop an extensive provider network to ensure that there are enough qualified providers to meet the needs of people with disabilities throughout the area and that each individual has a choice of qualified providers. This must include consideration of ways to bring services to people in isolated areas. LMEs shall also consider developing full-service one-stop settings where the vast majority of services can be accessed in one place for those people who have multiple service needs not easily met by solo or small group practices. All providers eligible for Medicaid or Medicare reimbursement shall be required to join the network in order to receive Medicaid or Medicare reimbursement. LMEs will identify qualified potential providers and facilitate their entry into the network. It may be necessary to develop incentives that encourage practice in rural or under-served areas. The State Plan calls for outcomes and performance standards of qualified providers to be recorded and reported. Future funding will depend on meeting these outcomes.

There are many secular and faith-based programs and services across the state that volunteer to provide human services and supports. The LME and DHHS shall encourage development of additional services of this nature. These providers who give so much to their communities will be important and respected partners in the statewide effort to provide services to the people who need them.

Department Coordination and Infrastructure

The state business plan implementation document and the state business plan timeline, which are included in this document, comprise the state's business plan. The State Plan requires fundamental change at the department/division level. The rules will be simple and straight forward. It is vitally important that DHHS divisions work closely together. DHHS will create a mechanism to coordinate policies and planning with its divisions to address administrative and business functions as well as programmatic and clinical guidelines, outcomes and initiatives. Attention will be given to Medicaid, Carolina Access, Health Choice, and public health policy coordination in order to promote coordinated care. The Department will also prepare a coordinated strategy for integration of the Olmstead, Long-Term Care and state MH/DD/SAS plans.

DHHS divisions will work together to develop and revise programmatic policy. Particular attention will be paid to areas where multiple divisions and departments work on similar issues such as employment, housing, transportation, workforce and long-term care issues. Coordination shall occur among DHHS divisions, and with the Governor's Advocacy Council for People with Disabilities, the departments of Commerce, Corrections and Transportation and the Housing Finance Administration.

This State Plan requires changes in Division practices, leadership methods and business functions. One of the first actions will be the selection of a division director who will assume responsibility for moving the system forward. The director will lead reorganization of the Division to accomplish the tasks outlined in the State Plan.

Coordination

Coordination must occur in these areas:

- Documentation of services.
- Licensure and monitoring of services.
- Direct enrollment including memoranda of agreement and qualified provider participation agreements, and collection and analysis of data to meet performance indicators and quality improvement activities.
- Training efforts throughout DHHS, within the Division and at all levels of the system so that all efforts complement each other and that content is appropriate, timely and provided regularly.

Documentation

Consumers and their legal guardians usually have the right to read their records. Staff will help consumers understand the content and their rights to privacy and the confidentiality of the information. Accurate documentation by all agencies is essential for assessing and monitoring the total service system and the person's progress over time. Reducing redundancy and extraneous elements is essential for a complete, accessible and accurate record. Medical record elements will be consistent, no matter the funding source or type of provider, and shall be shared only according to confidentiality laws and regulations. Record documentation will include:

- Consumer-specific information.
- Assessment and relevant information to support a person centered plan that should align all of the assistance the person is receiving, combining formal, informal and natural supports.
- Type of services to be delivered.
- Personal outcomes to be achieved as a result of the services of supports.
- Potential risks and crisis plans.
- Status and efforts to strengthen/sustain the primary circle of supports and recovery for the person.
- Proof of delivery of service or support including who provided the service, what service was provided, date and duration of the service, what was achieved as a result of the specific service.

Documentation requirements will be developed in coordination with other divisions within DHHS and across departments as applicable and shall include families, consumers and qualified providers as appropriate. Documentation requirements will be standard for a variety of divisions when possible. Documentation standards and requirements shall be the same for any qualified provider of services.

Qualified providers/agencies are accountable to the consumers served, to their communities and to their funding source. Qualified providers shall assume liability for the quality of the records. Local managing entities shall be responsible for ensuring qualified providers receive accurate and timely information. The Division and/or Department shall distribute materials directly to enrolled qualified providers.

Documentation is also essential for billing services to third parties (insurance companies, government agencies, other funding sources, etc). Third parties may arrange for periodic audits to ensure they are getting what they pay for. Records and charts will be examined during audits along with other relevant information and data. Public and private agencies shall be audited using the same standards and criteria except as mandated by federal or state law. The state shall establish audit criteria to be used. Results of audits, monitoring visits or investigations shall be published within 45 days of review and will be used for quality management activities and reports cards.

Licensure and Monitoring of Services

The Division of Facility Services (DFS) will serve as the regulatory agent for the state oversight of licensed services. DFS will be responsible for conducting inspections. Results of these inspections will be published and used as quality indicators for performance.

The LME will conduct local monitoring of qualified providers within the network. This local monitoring will focus on the quality of clinical and programmatic delivery and will not be considered a licensure inspection. Monitoring protocols and criteria will be standardized. All LMEs shall use state-adopted criteria and participate in rater training to improve consistency. The state, in collaboration with stakeholders, will develop the protocols and criteria.

Licensure for professional practitioners will be used as an indicator of qualification for service. Direct enrollment will be evaluated for all licensed practitioners. In the future, qualified providers of non-facility based services will be subject to licensure or compliance with identified standards.

Qualified Service Provider Network/Direct Enrollment

As part of the DHHS initiative to make services for children seamless, the State Plan will build upon existing practices of coordinating policies between Health Choice, Medicaid and state DMH/DD/SAS funding for all individuals. Children and adults who are eligible for Medicaid or Health Choice will continue to receive their benefits from qualified providers.

Direct enrollment requirements will be linked with licensure and performance of quality indicators. The ability to meet outcomes will be used to measure effectiveness and eventually payment of services. This shift has many implications and will be one of the final steps of implementation. As an interim step, reports of qualified provider performance will be published and will be an integral part of educating individuals and families about selection of qualified providers. These reports will also be used as a factor in examination of qualified provider rates.

Memoranda of Agreement (MOA) shall be required for direct enrolled qualified providers who make services available to target populations. These MOA shall be standardized and established by a participatory process including state staff, LME staff, qualified providers and consumer/family representatives.

Training

Training will be coordinated within the Division and DHHS. Training will:

- Reflect the latest research, best practices and state-adopted practices.
- Positively affect consumers.
- Be self-sustaining to the extent that individual training efforts are part of larger plans and continue on a regular basis.
- Be accessible across the state.
- Increase local capacity to provide services and supports.
- Result in permanent work place change.
- Be sensitive to all cultures.

Infrastructure

Collection and Analysis of Data

A variety of data shall be collected and analyzed for purposes of planning, establishing benchmarks, and informing decision-making. All area/county programs and other qualified providers shall participate fully in the state's efforts to study and evaluate system components.

The Pioneer System, now used to report services for payment, is being replaced by the Integrated Payment and Reporting System (IPRS). This is part of a major effort to upgrade the Division's management and information system, which includes a consolidated movement of data into a decision support warehouse. These changes require extensive revision of the statewide management information system capacity.

Appeals, Grievances, Human Rights, Consumer Advocacy

The mental health reform legislation requires a wide range of activities to ensure fairness, consumer choice, client rights and protections, client advocacy, and quality of care. There are also a number of existing avenues to address appeals, client/human rights and advocacy. The DHHS Secretary will study consolidation of these activities, and shall make a report of the findings and recommendations to the Joint Legislative Oversight Committee.

Office of Consumer Affairs

The Division of MH/DD/SAS will establish an Office of Consumer Affairs. The office will be lead by a consumer who reports directly to the Division Director and is a member of the Division's management team. The office will include a designated position from each of the service groups served through the Division and administrative support.

State and Local Consumer and Family Advisory Committees

The Division shall convene a state level consumer and family advisory committee and require each LME to convene a consumer and family advisory committee. The composition, staffing and recruitment of members, and the timing and links to other entities shall be as follows:

- Membership will be 100 percent consumers and family members.
- People representing all disability groups will be equally represented.
- Race and ethnicity of members will be representative of those who are served by the system.
- Each committee will have, for each disability group, a man, a woman and a youth member. Family members may represent children. A parent may represent the needs of parents of adult consumers, but shall not represent adult consumers.
- The state advisory committee will be staffed by the Office of Consumer Affairs coordinator, who will recruit the initial members of the state advisory committee in collaboration with consumer and family advocacy organizations.
- Each local advisory committee will be staffed by an employee of the LME whose responsibilities will be to obtain consumer and family input from the community, to implement recommendations of the advisory committee, and to serve as liaison to the state advisory committee and other local agencies, organizations and associations. This staff person will recruit the initial members of the local advisory committee in collaboration with local consumer and family advocacy organizations.
- The state committee and the local committees will be in place prior to the development of local business plans.
- State and local advisory committees will have clearly specified relationships to one another and to state and local consumer advocacy programs, human rights committees and the Governor's Advocacy Council for Persons with Disabilities.
- Local committees will have clearly specified relationships to county/area boards.
- Advisory committees will help educate elected officials and advocate for funding.

Local committees shall advise the LME regarding the local planning process and will review and submit to the state their own reports on local business plans. The state committee will review local plans and local committees' reports on plans and will make recommendations regarding state approval of local business plans.

State and local advisory committees will also:

- Review and advise regarding long term and annual state and LME plans.
- Provide recommendations regarding service eligibility and service array, including:
  - Identifying gaps in services.
  - Identifying under-served populations.
  - Advising regarding development of additional services, and
  - Monitoring service development and delivery.
- Review and monitor the state's budget for services and LMEs' budgets.
- Monitor the state and LMEs implementation of State Plan and local business plans.
- Educate state and local elected officials and advocate for funding.
- Review and advice regarding outcome date collection.
- Monitor tracking and reporting of outcomes.
- Monitor activities undertaken to improve quality.
- Ensure consumer and family participation in all quality improvement projects.

The Division and LMEs will support state and local Consumer and Family Advisory Committees with:

- Stipends as appropriate to ensure participation.
- Transportation or compensation for travel expenses.
- Childcare and eldercare if needed.
- Flexible scheduling of meeting times.
- Information and education regarding the service system:
  - User-friendly primer regarding existing system and funding sources.
  - List of the services that are available and how to access them.
  - Materials regarding model systems and best practice services/supports.

Rules Adoption and Statute Revisions

There are many existing rules and statutes that do not support the implementation of the State Plan and that are actual barriers to its mission and goals. The department will complete a review of all rules for vagueness, duplication and ambiguity. This review shall be a participatory process involving people with disabilities and their families, qualified providers and advocates.

In addition to existing rules, the department will use the rule making process to establish service standards, procedures for rate setting and for establishing qualified provider standards. The Division of Medical Assistance (DMA) and the Division of MH/DD/SAS will cooperatively plan any policy or rule making in order to meet the mission of a unified system and to meet statutory requirements of both agencies for rules and policies.

This plan requires realignment of service definitions and standards in order to meet management information system requirements and array of services for targeted population, licensure rules, documentation requirements, clinical care guidelines, medical necessity criteria, monitoring requirements, readiness reviews of LMEs, and competencies for staff.

System Quality Management Plan

A quality management program for North Carolina's mental health, developmental disabilities, and substance abuse services system will promote accountability, efficiency, human rights, and continuous improvement in the quality of treatments, services, and supports provided to consumers. Components of this system will include:

- Utilization review activities at state facilities, at LMEs and with qualified providers.
- Utilization management using standardized review criteria of services provided with public funding.
- Quality assurance including licensure, credentialing, program monitoring, and financial audits.
- Quality improvement activities conducted throughout the system.

System-wide quality management and improvement will be coordinated by a committee that includes consumers, families and other stakeholders.

Report Cards
To assess and broadcast performance results for the system, periodic report cards will be issued. These report cards will consist of an easy to understand evaluation format for a range of performance and consumer outcome measures. Report cards will be publicized across the state in a variety of different ways.

Domains	Sample Indicators for Report Cards
Access	• Penetration rate (percent of eligible consumers who access services and supports) • Timeliness of receiving services and supports • Adequacy of qualified provider network (capacity)
Quality of Care	• Engagement/retention in treatment • Continuity of care and care-givers • Completion of consumer-driven, clinically appropriate and evidence-based service plans • Consumer/family education
Administrative Processes	• Collaboration of consumers, families, and public and private agencies in planning and monitoring • Effectiveness of system quality improvement processes and activities • Training competency, service standards, best practices including cultural competence
Consumer Outcomes	• Core Indicators Project • Client Outcomes Inventory

Staff Competencies, Education and Training
A competency-based system for qualified providers services providers has been developed to achieve measurable outcomes and raise the level of quality and consistency statewide for the delivery of human services. This effort is consistent with the national move toward competency-based requirements for billable services. Recognition is also given to those licensing and certification boards already in place and serving well the people with disabilities.

There are seven core competencies required to meet the minimal standards for a competency-based system for staff services in North Carolina:
1. Technical knowledge
2. Cultural awareness
3. Analytical skills
4. Decision-making
5. Interpersonal skills
6. Communication skills
7. Clinical skills

Several implementation phases are necessary to build a solid, cost effective, stable system that will achieve measurable objectives. The rewards of a competency-based qualified provider system will be:

- Better personal outcomes for people with disabilities through more stable support systems.
- Less staff turnover and reduction of associated costs with replacing and training new personnel.
- Reduction in administrative costs through standardizing qualifications and competencies for professionals and paraprofessionals.
- Improved professional ethics and standards.
- Higher morale and more motivated employees.
- Streamlined, cost effective statewide standardization of qualification and documentation processes for professionals and paraprofessionals.
- Improved quality outcome indicators that can be measured against national standards (accident injury rate, staff turnover, etc.).

Financing

In North Carolina, a number of agencies serve people with mental health, developmental disabilities and substance abuse service needs. Each has its own mandates, funding priorities and procedures. Funding categories, which limit the ability to move funds to where they may be most needed, further fragment service delivery. Funding fragmentation provides little incentive to work with other systems and actually creates incentives to continue to operate independently of other systems. There are few incentives that encourage shared or coordinated funding. This plan requires shared planning among state and local partners.

While present funding does not match the level of need, better coordination among existing funding sources will make better use of available resources. Funding must follow the consumer.

During the 2001 legislative session, $47.5 million was appropriated to establish a trust fund for mental health, developmental disabilities and substance abuse services. This fund provides bridge dollars to expand community capacity, assist in the implementation of the Olmstead plan and encourage joint agency ventures in innovative community options such as housing, transportation and meaningful employment.

Funding must follow the person upon discharge from state facilities. This will require re-alignment of funds and making use of funds available to transfer people from institutions to community intermediate care facilities. Funding realignment and consumer discharges shall be coordinated to allow for state facility downsizing and expanding community capacity. This action meets the requirements as outlined in the Olmstead Plan. It helps people who have lived together in state facilities continue to live together in community settings, thus nurturing relationships in the community. Increasing community capacity to provide services and providing ongoing funding sources will be needed.

Funding links between LMEs and use of state facilities must exist. The state shall establish a bed-day allocation system for use of state hospitals, and a similar plan shall be developed for referral to the mental retardation centers and residential schools.

Funding LME functions must be separated from funding of service delivery. Currently, administrative dollars are tied directly to the delivery of units of direct service. As the LME moves from providing services to managing services, payment for these administrative/ management functions will be distinct from payments for services to people with disabilities and their families. Federal dollars must be leveraged to fund administrative functions.

Funding for services to people with disabilities and their families must be based on realistic costs and expectations. Services that do not meet national standards, or do not meet desired outcomes will not be funded. Medicaid and state funding shall be re-aligned to implement this plan. This includes adoption of new and revised service and support definitions, new and revised Medicaid waivers and examination of blending funding with other agencies.

Analysis and cost modeling of all components must be coordinated with the Legislative Oversight Committee's review of financing the system. This analysis includes core functions, LME activities, target populations and proposed benefit packages, training and monitoring the quality management plan.

Chapter 4. Business Plan Timeline

The State Plan implementation steps shown here were developed using a project management software application. The elements and parameters of this implementation plan will be steadily broadened and refined to include increasing levels of detail and timeframes as they are identified. As they are approved, steps that must be led or performed by the Department will be shown on the project list as well as all transition steps from the Department, project teams, LME's and community partners. In this way, everyone involved can know about any changes, follow progress and review accomplishments.

ID	TASK NAME	TASK COMPLETION DATE
1.	Initiate plan to coordinate policies and planning with other divisions to address administrative and business functions, funding sources, as well as programmatic & clinical guidelines, outcomes and initiatives	11/30/01
2.	Provide initial report to Legislative Oversight Committee on state plan, and quarterly thereafter on each required activity listed below.	11/30/01
3.	• Submit the State MH/DD/SAS Plan to the Legislative Oversight Committee	11/30/01
4.	• Review of rules and statutes inside and outside DHHS	11/30/01
5.	• Review oversight & monitoring functions implemented • by DHHS	11/30/01
6.	• Report on development of service standards, outcomes, financing formula for core and targeted services, to prepare for their admin, financing & delivery by area authorities/county programs	11/30/01
7.	• Develop format & required content for business plans submitted by boards of county commissioners & for contractual agreements between DHHS & area authorities/county programs	11/30/01
8.	• Assessment of DHHS readiness for reform implementation	11/30/01
9.	Expand service capacity for substance abusers to assist in diversion from state psychiatric hospitals	11/30/01
10.	• Division of Facility Services to give priority consideration to construction on projects related to the development of service capacity	11/30/01
11.	• DHHS personnel to expedite additional staffing needs of Alcohol & Drug Abuse Treatment Centers (ADATC)	11/30/01
12.	New Director of MH/DD/SAS announced	01/01/02
13.	DD to convene workgroup to build plan for integrating private Intermediate Care Facilities/MR into unified community-based system	01/01/02
14.	Prepare, with the County Commissioner's Association, a technical	01/01/02

ID	TASK NAME	TASK COMPLETION DATE
	assistance/communication plan for decision regarding Letters of Intent.	
15.	Distribute revised service record manual to field staff for review	01/01/02
16.	Submit a research waiver for consumer directed services for people with developmental disabilities	01/01/02
17.	Revise service definitions for July implementation of Integrated Payment & Reporting System (IPRS) statewide rollout & establish plan for:	01/01/02
18.	• Submit changes to Medicaid Plan & coordinate with Health Choice & state funding as needed	01/01/02
19.	• Promulgate rules & publication of activities as required by the rule-making authority (G.S. 150B) & new Medicaid legislation	01/01/02
20.	• Analyze financial impact	01/01/02
21.	• Begin training of staff & field staff	01/01/02
22.	• Set rates for new services	01/01/02
23.	• Electronic Data Systems (EDS) & IPRS programming	01/01/02
24.	Begin establishment of licensure rules through MH Commission on MH/DD/SAS for prevention program	01/01/02
25.	• Develop criteria for qualified prevention professional	01/01/02
26.	Based on Olmstead assessments, analyze services needed to facilitate discharge of patients from state hospitals and reduce admissions to such hospitals.	01/31/02
27.	Complete annual public review of plan	03/01/02
28.	Present progress report to LOC on the status of state plan implementation	03/01/02
29.	Establish outpatient crisis teams from state facilities to develop re-integration plans	03/01/02
30.	Report to Appropriations Committee finding of Section 21.28A of Senate Bill 1005, Traumatic Brain Injury Waiver	03/01/02
31.	Implement plan to divert substance abuse admissions from state psychiatric hospitals	03/01/02
32.	• Complete renovation of 3 ADATCs for 90 additional beds	03/01/02
33.	• Recruit & hire for 90 additional beds	03/01/02
34.	Develop multilevel integrated quality management committee structure including consumers, families and other stakeholders	03/01/02
35.	Develop and/or strengthen collaborative agreements with community college systems, DPI, colleges and universities, Area Health Education Centers & associated training vendors to establish training for state plan, best practices including cultural competence & staff competencies	03/01/02
36.	• Develop & present funding needs for competency programs	03/01/02
37.	• Complete content competencies for each curriculum & establish inter-rater reliability	03/01/02
38.	Complete 1 through 5 year financing plan to support mission core services, target populations, LME functions, state functions, bed-day allocations, mental retardation center downsizing, leveraging funds from state facilities & Mental Health Trust Fund & evaluate sharing of funding for functions that cross agencies	03/01/02

ID	TASK NAME	TASK COMPLETION DATE
39.	• Review current allocations of state funding to area authorities/county programs & recommend changes in methods & formulae to ensure equitable distribution of state funds & evaluate means of increasing/realigning funding to stabilize & support MH/DD/SAS	03/01/02
40.	• Develop accurate picture of current resource allocation in the MH/DD/SAS System including current methods of funding & disparities	03/01/02
41.	• Develop a realignment plan of state facility resource	03/01/02
42.	• Develop a dedicated source of ongoing of state & federal funding for the system	03/01/02
43.	• Examine ways to obtain additional funding through traditional/non-traditional means	03/01/02
44.	• Complete analysis and make recommendations for direct/indirect cost of qualified public/private providers	03/01/01
45.	Develop criteria & operational procedures for the Consumer Advocacy Program	03/01/01
46.	Develop the DHHS Appeals Panel for clients and family members, as well as qualified providers	03/01/02
47.	Evaluate consolidation of the Quality of Care Consumer Advocacy Program w/other consumer advocacy/ombudsman programs in DHHS and report to the LOC. Include Consumer Advocacy Programs, Office of Consumer Affairs	03/01/02
48.	Establish training & promotion strategies for state plan	03/01/02
49.	Present integration of the Olmstead, Long-term Care & State MH/DD/SAS plans	03/01/02
50.	Review financing options for interpretation/translation services to people being served and make specific recommendations	03/01/02
51.	Initiate expansion of community support services for adults with mental illness in order to facilitate closure of state hospital beds.	03/28/02
52.	Provide financial and/or technical assistance to LME's to enhance service development/provision to the adult mental health target population.	04/30/02
53.	Complete analysis and make recommendations for direct/indirect cost of qualified public/private providers	05/01/02
54.	Open admissions at 3 ADATCs to involuntary substance abuse admissions	05/01/02
55.	Adopt a standardized assessment & treatment protocol and provide regional training to area authority/county program and ADATC staff in order to carry out diversion of substance abuse clients to state hospitals	05/01/02
56.	Present recommendations regarding expansion of direct enrollment of qualified providers & possibly agencies	05/01/02
57.	Complete annual State Plan modification	06/01/02
58.	Update all Memoranda of Agreement (MOA) for July implementation	06/01/02
59.	Complete data gathering and analysis related to geographic (catchment) area consolidation plan	07/01/02
60.	Complete review of state plan for FY 02-03 implementation	07/01/02
61.	Submit quarterly report for LOC on status of state plan implementation	07/01/02

ID	TASK NAME	TASK COMPLETION DATE
62.	Increase target populations of children w/severe impairment & their families to be served through SOC	07/01/02
63.	• FY 2002-6000 youth/families (doubling 3,000 baseline of youth served in System Of Care (SOC) currently eligible for At Risk SOC in 100 counties)	07/01/02
64.	Establish annual 5 year benchmarks to: 1) strengthen school counseling programs, primary care linkage & qualified provider networks through SOC approach for 253,407 with mild/moderate impairment; 2) incorporate prevention through SOC targeting 1,851,191 youth pop.	07/01/02
65.	Assess with Community Collaborative the current service array & gaps in services to establish baseline	07/01/02
66.	Develop local services to reduce the number of children in state hospitals, DSS custody & Youth Development Centers	07/01/02
67.	Increase capacity using 3% of Child Mental Health funds pool (approx. 1.5 million) for comprehensive treatment services special provision to children with highly complex needs	07/01/02
68.	SOC for children At Risk or already out-of home operational in 30 counties	07/01/02
69.	Refine collaborative plan with other child-serving agencies/communities to expand resources through integration of services	07/01/02
70.	Increase/add resources for CMH at the community level at 25%	07/01/02
71.	Recommend integrated SOC structure that includes JCPC through legislation/executive order to reduce duplication	07/01/02
72.	Establish flexible funds & voucher resources across all disabilities	07/01/02
73.	Modify CAP/MR-DD waiver to expand community-based services	07/01/02
74.	Initiate rule revisions on an ongoing basis as systems & policies are implemented	07/01/02
75.	Eliminate 72 state psychiatric hospital beds & transfer patients to community	07/01/02
76.	• Dix Hospital 39 beds-close Wright Building	07/01/02
77.	• Broughton Hospital 18 beds-close nursing facility	07/01/02
78.	• Umstead Hospital close 15 gero-psychiatry beds	07/01/02
79.	Systematically and on ongoing basis, redirect funds from state hospitals to community services for substance abuse, mental health, child mental health to expand community services	07/01/02
80.	Prepare Eastern Adult Treatment Program, Whitaker & Wright Schools for Medicaid certification	07/01/02
81.	Develop cross agency policy recommendations for statewide outcomes based SOC best practices consistent with state plan	07/01/02
82.	Implement comprehensive outcome measurement plan with elements across agencies and develop framework for outcome report cards	07/01/02
83.	Implement SA standardized risk assessment protocol and pilot use in 10 communities	07/01/02
84.	Develop 2 pilot projects from ICF-MR homes to community support using CAP-MR/DD funds	07/01/02
85.	Mental retardation centers & private sector develop 5- bed homes in	07/01/02

ID	TASK NAME	TASK COMPLETION DATE
	community for those person previously unsuccessful in community placements	
86.	HB 1395 Transfer-ICF-MR beds to transfer at least 40 people from mental retardation centers to community ICF-MR beds	07/01/02
87.	Develop & operate three 12-bed specialized MR/MI units one for children, two for adults in each of the 3 MRCs to serve moderate to severe MR & MI for crisis intervention, diagnosis & treatment	07/01/02
88.	Convert Black Mountain Center ICF-MR beds to Skilled Nursing Facility to serve aging persons with DD & medical care needs	07/01/02
89.	Develop MH/DD/SA protocols based on evidence-based practices and/or national standards of service delivery	07/01/02
90.	• Develop service definitions consistent with evidence-based services/expert consensus	07/01/02
91.	• Update clinical guidelines for client assessment, schizophrenia, mood disorders, substance related disorder and psychiatric issues in persons with MR	07/01/02
92.	• Making use of Robert Wood Johnson/SAMHSA and other national tool kits as appropriate, review & evaluate standards on person-centered planning, cultural competence, Assertive Community Treatment, psychiatric rehabilitation and case management for adults with severe and persistent mental illness, schizophrenia outcomes research, dual disorders, dialectical behavioral treatment.	07/01/02
93.	Develop specs for DHHS management information system including decision support & build upon Medicaid MIS & IPRS for DHHS coordination; manage coordination at department level	07/01/02
94.	Develop Memoranda Of Agreement between state & local agencies including qualified provider enrollment agreement and qualified provider/LME agreements	07/01/02
95.	Establish local monitoring protocols for use by LME & credential local auditors; coordinate with Division of Facility Services licensure review including relationship with national accreditation & deemed status	07/01/02
96.	Establish Office of Consumer Affairs that is consistent with Division reorganization	07/01/02
97.	Develop readiness plan for conducting reviews & certifying area authorities/county programs as LME's.	07/01/02
98.	Reduce child out-of-state placements by 25%	07/01/02
99.	Promote increased flexibility of child-serving funds-develop mechanisms in 100 counties to de-categorize 1-5% of child-serving agency funds	07/01/02
100.	Establish regional learning center-engage university & community college systems with team of specialists of trainers in each region for TA in best practices and trouble-shooting. One center per year for 4 years	07/01/02
101.	Identify all existing outcome tools and data collection efforts across agencies that can contribute to one integrated data set to measure indicators regarding specified outcome targets	07/01/02

ID	TASK NAME	TASK COMPLETION DATE
102.	Present quarterly report to the LOC on the status of State Plan implementation	10/01/02
103.	Receive and act on letters of intent from counties regarding LMEs	10/01/02
104.	Develop criteria for performing Utilization Management including centralized functions & LME functions	10/01/02
105.	• Develop budget & fee structure for UM functions	10/01/02
106.	• Develop criteria for measuring the performance of the UM entity on an ongoing basis	10/01/02
107.	• Begin process for the selection of a vendor	10/01/02
108.	• Determine process & content of UM information to state & LME	10/01/02
109.	Present quarterly report to the LOC on the status of state plan implementation	11/29/02
110.	Develop and maintain a mh/dd/sa competency, education and training system that is coordinated among system members & is based on best practices including cultural competence, professional competencies, and performance standards	11/29/02
111.	Develop & maintain a workforce that is reasonably compensated	11/29/02
112.	• Develop & periodically update career enhancement procedures for the MH/DD/SA system	11/29/02
113.	• Perform regular salary reviews to ensure a workforce that is reasonably compensated at the local community level (public & private)	11/29/02
114.	Each area authority/county program submits their proposed business plan to the DHHS Secretary	01/01/03
115.	Establish licensure categories for agencies providing non-facility based services & begin rule making	01/01/03
116.	Create separate Home and Community Based (HCB) waiver for persons leaving institutions	01/01/03
117.	Reduce alcohol, tobacco & other drugs (ATOD) usage by children between the ages of 12-17	01/01/03
118.	• Work with Center for Substance Abuse Prevention to identify a menu of approved prevention services	01/01/03
119.	• Develop prevention service system, definitions, staff competencies & outcome criteria	01/01/03
120.	• Initiate negotiations with Medicaid & other payers to establish rates & approve reimbursement for prevention services in NC	01/01/03
121.	Complete annual public review of plan	03/01/03
122.	Establish a 24-bed substance abuse crisis triage unit and complementary intensive outpatient program for Wake County	03/28/03
123.	• Identify & renovate an appropriate facility	03/28/03
124.	• Recruit & hire staff	03/28/03
125.	• Evaluate progress in development and implementation of	03/03/03

ID	TASK NAME	TASK COMPLETION DATE
	seamless electronic communication systems across agencies and qualified providers (MMIS/IPRS, etc.)	
126.	Complete annual plan modification	06/01/03
127.	Present quarterly report to the LOC on the status of the State Plan implementation	07/01/03
128.	Re-engineer home & community-based waiver services to reflect Human Service Research Institute recommendations	07/01/03
129.	Continue expansion of local community child and adolescent service array increasing resources at the community level by 35%	07/01/03
130.	Continue rollout for county integrated child SOC to cover 50 counties	07/01/03
131.	Increase target population of children with severe impairment to be served by SOC to build capacity for 18,000 youth/families	07/01/03
132.	The Secretary shall complete certification of 1/3 of area authorities/county programs as LME's	07/01/03
133.	Develop statewide contract for referral system component for Uniform Portal	07/01/03
134.	Reduce additional 154 adult state hospital beds & substitute with community based services including pilot projects for specialized residential services, community nursing facilities, and other supports	07/01/03
135.	Rollout a reimbursable substance abuse prevention benefit for 1,500 children and their families	07/01/03
136.	Establish 2nd of 4 regional learning centers to provide ongoing TA & troubleshooting for system	07/01/03
137.	Refine comprehensive outcome plan including common elements from other agencies for cross-agency outcome report cards	07/01/03
138.	Complete research & development of uniform set of funding band criteria to transition to a new resource allocation system	07/01/03
139.	Present quarterly report to the LOC of the status of the state plan implementation	12/01/03
140.	DHHS Secretary shall complete certification of two-thirds of the area authorities/county programs as LME's	01/01/04
141.	Complete annual public review of plan	03/01/04
142.	Present quarterly report to the LOC on status of state plan implementation	03/01/04
143.	Develop 5 additional community based substance abuse crisis triage units with Intensive Outpatient treatment programs	03/01/04
144.	Complete annual plan modification	06/01/04
145.	Present quarterly report to the LOC on the status of state plan implementation	07/01/04
146.	Continue cross-agency approaches to comply with Olmstead and comprehensive treatment program special provision by reducing out-of-state child placements 75%	07/01/04
147.	Reduce number of children inappropriately in state hospitals, DSS custody and youth development centers by redirecting funds from state hospitals to established local & semi-regional alternatives to increase by 25%	07/01/04
148.	Continue rollout schedule for counties to use SOC to 70 counties	07/01/04

ID	TASK NAME	TASK COMPLETION DATE
149.	Increase target population of children with severe impairment to 36,000 youth/families	07/01/04
150.	Reduce ATOD use by children 12-17 by standardized data collection for measuring outcomes and to begin risk profiling of this group	07/01/04
151.	Continue to reduce state hospital placements for children by establishing 4 regional assertive community treatment teams in conjunction with 4 semi-regional psychiatric hospitals	07/01/04
152.	Continue to increase/add resources for child community service array by 50% and SOC for children & youth operational in 80 counties	07/01/04
153.	Establish number 3 out of 4 regional learning centers to provide ongoing TA and trouble shooting for statewide system	07/01/04
154.	DHHS Secretary shall complete certification of all area authorities/county programs as LME's	07/01/04
155.	Eliminate additional 212 state adult hospital beds	07/01/04
156.	• Integrate & refine community planning based on state plan	07/01/04
157.	• Expand specialized nursing bed capacity by 20 beds at 4 sites	07/01/04
158.	• Expand specialized residential service with 12 beds at 6 sites	07/01/04
159.	• Place 60 people in community programs based on Olmstead assessments	07/01/04
160.	Present quarterly report to the LOC on the status of state plan implementation	09/01/04
161.	Present statewide system report card covering the plan implementation, client outcomes and system reform	09/01/04
162.	Present quarterly report to the LOC on the status of State Plan Implementation	12/01/04
163.	Present the Secretary's area authority/county program consolidation plan to the LOC	12/31/04
164.	Complete annual public review of plan	03/01/05
165.	Present quarterly report to the LOC on the status of the state plan implementation	03/01/05
166.	Develop 10 additional community step down residential alternatives with Intensive Outpatient Program for substance abusers	03/01/05
167.	Complete annual plan modification	06/01/05
168.	Present quarterly report to the LOC on the status of the state plan implementation	07/01/05
169.	SOC for children shall be operational in all 100 counties	07/01/05
170.	Continue to reduce children in state hospitals, DSS custody and youth development center by re-directing funds from state hospitals to local and semi-alternative regional alternatives	07/01/05
171.	State plan should be substantially implemented with continuing build-up of service array of SOC, evidence-based practices, ongoing indices accomplishment and areas of improvement	07/01/05
172.	Strategies and schedules for implementing a phased in plan to eliminate disparities in the allocation of state funding across county programs and area authorities	01/01/07

ID	TASK NAME	TASK COMPLETION DATE
173.	The total number of area authorities and county programs shall be reduced to no more than 20	01/01/07
174.	Persons served in mental retardation centers reduced 50%	01/01/07

References

Annual Statistical Report North Carolina Alcohol and Drug Abuse Treatment Centers: Fiscal Year 2000. North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, March 2001.

Annual Statistical Report North Carolina Mental Retardation Centers: Fiscal Year 2000. North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, March 2001.

Annual Statistical Report North Carolina Psychiatric Hospitals: Fiscal Year 2000. North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, March 2001.

Annual Statistical Report North Carolina Special Care Centers, Whitaker School, Wright School: Fiscal Year 2000.North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, March 2001.

Adams, J., Bliss, C., Mohammad, V.B., Meyers, J., & Slaton, E.*, Family-Professional Relationships: Moving forward Together*. Washington, DC: National Peer Technical Assistance Network's Partnership for Children's Mental Health, 1997.

A Long-term Care Plan for North Carolina: Final Report. North Carolina Institute of Medicine Long-term Care Task Force. March 15, 2001.

A Strategic Plan for Public Health System Improvement in Montana. Montana Department of Public Health and Human Services, March 2000.

California State Medicaid Plan.

Changing Lives – Ohio's Action Agenda for Mental Health. Ohio's Mental Health Commission, January 2001.

Children's System of Care Initiative. New Jersey Department of Human Services, 2001. http://www.njkidsoc.org/main-fs.htm

Defining Medically Necessary Services to Protect Children (#5): Protecting Consumer Rights in Public Systems. Bazelon Center for Mental Health Law. 1998. http://www.bazelon.org/children.html

Developmental Disabilities Waiting List Data, North Carolina, July, 2001.

DMH/DD/SAS System Redesign Plan: Analyses, Options, and Recommendations. North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services, 1999.

Family Support for Families of Persons with DD in the US: Status and Trends. Policy Research Brief, University of Minnesota, 2000.

Gettings, Robert M. *Building a Comprehensive Quality Management Program for Developmental Disabilities Service Systems: Organizing Principles and Primary Operating Components.* National Association of State Directors of Developmental Disabilities Services.

Gettings, Robert M. *Identifying the Underlying Principles and Primary Components of a Comprehensive Quality Management Program for Public Developmental Disabilities Services systems.* National Association of State Directors of Developmental Disabilities Services, December 2000.

Grimm, Jeffrey A., *Total Quality Improvement: Philosophy and Plan.* Trend Community Mental Health Services.

Guide to Quality Assurance and Quality Improvement. Oregon Mental Health and Developmental Disability Services Division.

Improving Montana's Mental Health System – Final Report. The Technical Assistance Collaborative, Inc.

Kaufman, M.C., Moss, S., *A Proposed Managed Mental Health "System of Care" for Children, Youth, and Families In North Carolina.* DHHS/DMHDDSAS System Redesign and Reform Paper. The Moss Group for The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, 2000.

Massachusetts State Medicaid Plan.

Myers, A., Realon, R, Thompson, T., *Development and Validation of a Needs-Assessment Instrument for Persons with Developmental Disabilities.* August 2001 (submitted for review)

New Hampshire State Medicaid Plan.

New York State Medicaid Plan.

New York Statewide Comprehensive Plan for Mental Health Services 2001-2005.

North Carolina Area Programs Annual Statistical Report: Fiscal Year 2000. North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, March 2001.

North Carolina Olmstead Plan

North Star Contract for Services between the Texas Department of Mental Health and Mental Retardation and Texas Commission on Alcohol and Drug Abuse and Contractor.

Ohio State Medicaid Plan.

Oregon State Medicaid Plan.

Pennsylvania State Medicaid Plan.

Principles of Drug Addiction Treatment: A Research-Based Guide. National Institute on Drug Abuse, NIH Publication No. 99-4180, October 1999.

Promising Practices Handbook: Strategies to Improve the Effectiveness of Your Planning Council. National Technical Assistance Center,

Proposed Strategic Plan 2000-2005. California Department of Developmental Services, 2000.

Public Consulting Group, Inc. *Study of State Psychiatric Hospitals and Area Mental Health Programs: State of North Carolina Final Report.* April 1, 2000.

Quality Improvement: An Introduction to QI Methods Using POMS and Other Data. State of Virginia.

Release Policies to Support Home and Community Waivers. Centers for Medicare and Medicaid Services, NASDDD, Perspectives, Sept. 2000.

Remaking DHS: Reorganizing the Oregon Department of Human Services to Better Serve Oregonians. Oregon Department of Human Services, February 2001.

Residential Trends. American Association of Mental Retardation, AAMR, Vol. 39, #4, August , 2001.

Satcher, David, *Mental Health: A Report of the Surgeon General.* Department of Health and Human Services, Washington, DC, 1999.

South Carolina State Medicaid Plan.

Tennessee State Medicaid Plan.

Texas Health and Human Services Community Forum Planning Guide. March 1, 2001.

The National Data Project on Day and Employment Services. Institute for Community Inclusion, Children's Hospital, Boston, Massachusetts, Nov, 2000.

The State of the States in DD. Department of Disability and Human Development, University of Illinois at Chicago, 2001.

VanDenBerg, J.E., & Grealish, E.M., *Individualized Services and Supports Through the Wraparound Process: Philosophy and Procedures.* Journal of Child and Family Studies, 5(1), 7-21, 1996.

Welch, Britton D., *Proposed Framework for Implementing Continuous Quality Improvement within the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.* North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse, June 1999.

Zirps, Fotena A., *Doing It Right the First Time: A Model of Quality Improvement for Human Service Agencies*. The Florida Institute of Quality Improvement, Inc., 1997.